EMERGENCY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing providers' National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Emergency department care must be provided by an enrolled hospital with a designated emergency department. Professional services may be provided by enrolled physicians, physician assistants, and certified nurse practitioners.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage of emergency services is restricted to emergencies related to renal failure.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Determination of Emergency Hospital Care
The physician or other licensed practitioner on duty or on call at a hospital must determine whether the recipient requires emergency hospital care using the prudent layperson standard.

Per the Prudent Layperson standard an “emergency medical condition” is a medical condition manifesting with acute symptoms of enough severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Death;
- Additional serious jeopardy to the individual's health or with respect to a pregnant woman, the health of the woman or the unborn child;
- Serious impairment to the individual's bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency hospital care for a pregnant woman having contractions includes care provided when:

- There is inadequate time to safely transfer to another hospital before delivery, or
- Transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency hospital care does not include treatment that is available and routinely provided in a clinic or licensed practitioner's office.

Emergency Department Screenings
Under the Emergency Medical Treatment and Active Labor Act, Medicare participating hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize the condition.
If the examining provider determines that an emergency medical condition exists according to the prudent layperson standard, South Dakota Medicaid covers medically necessary services utilized for screening, stabilization, and treatment of emergency conditions.

Examples of Emergencies

Examples of medical conditions that meet the prudent layperson standard, include, but are not limited to:

- Decreased consciousness or not being able to respond to questions;
- Chest, head, or eye injuries;
- Difficulty breathing or extreme shortness of breath;
- Extreme bleeding;
- Accidental poisoning;
- Sexual assault and abuse;
- Burn with blisters;
- Pain or tightness in chest;
- Drug overdose;
- Feeling you might hurt yourself or others; and
- Breathing tube blockage.

E/M Services

Emergency department physicians and other licensed practitioners who render emergency services as determined using the prudent layperson standard should bill using CPT codes 99281-99285 to reflect the appropriate level of screening exam. The following are clinical examples providers should use to determine the correct code to bill. Refer to the CPT codebook for additional examples:

CPT Code	Clinical Examples
99281 - Emergency department visit, self-limited or minor problem	• Emergency department visit for a patient for removal of sutures from a well-healed, uncomplicated laceration. • Emergency department visit for a patient for tetanus toxoid immunization. • Emergency department visit for a patient with several uncomplicated insect bites.
99282 – Emergency department visit, low to moderately severe problem	• Emergency department visit for a 20-year-old student who presents with a painful sunburn with blister formation on the back. • Emergency department visit for a child presenting with impetigo localized to the face. • Emergency department visit for a patient presenting with a rash on both legs after exposure to poison ivy. • Emergency department visit for a patient with localized pain, swelling, and bruising (no imaging done).
99283 – Emergency department visit, moderately severe problem	• Emergency department visit for a well-appearing 8-year old who has a fever, diarrhea, and abdominal cramps; is tolerating oral fluids and is not vomiting. • Emergency department visit for a patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.

	• Emergency department visit for a healthy, young adult patient who sustained a blunt head injury with local swelling and bruising without subsequent confusion, loss of consciousness, or memory deficit.
99284 – Emergency department visit, problem of high severity	• Emergency department visit for a 4-year-old who fell off a bike sustaining a head injury with brief loss of consciousness. • Emergency department visit for a patient with flank pain and hematuria.
99285 – Emergency department visit, problem with significant threat of life or function	• Emergency department visit for a patient with a complicated overdose requiring aggressive management to prevent side effects from the ingested materials. • Emergency department visit for a patient exhibiting active, upper gastrointestinal bleeding.

South Dakota Medicaid recognizes codes 99291 and 99292 for reporting critical care services provided by a physician or other licensed practitioner. Provider must follow the guidelines and definitions established in the most current version of the CPT codebook.

Care Management Referral

Emergency Care

Emergency care determined to meet the prudent layperson standard does not require aCare Management referral.

Urgent Care

Urgent care in an emergent setting must be referred for Care Management recipients. If no referral is provided, only the ER room and the physician or other licensed practitioner's screening services are covered. Elective care that is nonemergent or urgent must be referred by the PCP or HH for recipients enrolled in those programs. Up to 4 urgent care visits per fiscal year (July 1 – June 30) in a non-emergent setting are exempt from referrals for recipients in the PCP or HH programs. For billing instructions please refer to the CMS 1500 Claim Instructions.

Providers may elect to provide a retroactive referral for ER services as stated in the Referral manual.

Upon discharge all medically necessary follow-up services incidental to an ER visit must be PCP/HH referred/authorized. The recipient's PCP/HH will determine the need for specialty and follow-up treatment.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Emergency Services
Services not covered in an emergency department include:

- Nonemergent services provided to a recipient in a Care Management program without a referral;
- Scheduled care in the emergency department; and
- Unattended waiting time.

Services provided as follow-up to initial emergency care are not considered emergency services.

Documentation Requirements

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Emergency Services Documentation
Medical records must document the emergency diagnosis and the extent of direct patient care.

Reimbursement and Claim Instructions

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Professional Services
Physician and other licensed practitioner services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Physician Services fee schedule. Elective services provided to a recipient in Care Management programare only reimbursable with a Care Management provider referral.

Facility

Facility charges for emergency department visits are reimbursed in accordance with the provider's outpatient hospital payment methodology.

If a recipient in the PCP/HH program is provided urgent care in an emergency department without a referral from their PCP/HH provider, only the 450 revenue code is reimbursed. The 450 revenue code must only be billed once per visit and must include the applicable CPT code(s). Hospitals are reimbursed for the 450 revenue code according to their standard reimbursement methodology.

If the emergency department visit results in an inpatient stay, reimbursement is based on the hospital's inpatient reimbursement methodology.

Reimbursable Emergency Department Services Summary

Category	Claim Type	PCP/HH Referral	Reimbursement
Emergent services	Professional	Not Required	Standard methodology
Emergent services	Facility	Not Required	APC Hospitals Standard methodology. Other Hospitals Standard methodology for Revenue code 450.
Urgent services	Professional	Required for PCP/HH participants	With referral: Services are reimbursed according to the standard methodology. Without referral: Screening services are covered. Ancillary services are not covered.
Urgent services	Facility	Required for PCP/HH participants	With referral: APC Hospitals Standard methodology. Other Hospitals Standard methodology for Revenue code 450. Without referral: APC Hospitals Standard methodology for Revenue code 450.

			Other Hospitals Standard methodology for Revenue code 450.
Elective services	Professional	Required for PCP/HH participants	With referral: Services are reimbursed according to standard methodology. Without referral: Services are not covered.
Elective services	Facility	Required for PCP/HH participants	With referral: APC Hospitals Standard methodology. Other Hospitals Standard methodology for Revenue code 450. Without referral: Services are not covered.

Claim Instructions

South Dakota Medicaid expects both the professional and facility claim to align in their classification of the service. For example, if the services are emergency both claims should reflect this in the appropriate block/locator on the claim.

Professional Services

Physician and other licensed practitioner services must be billed using a CMS 1500 claim form or 837P electronic transaction. Services that meet the prudent layperson standard must be billed with a "Y" in the emergency indicator field in Block 24c of the CMS 1500 or the 837P equivalent field. South Dakota Medicaid expects claims for CPT codes 99284 and 99285 to be billed with a "Y" in Block 24c Emergency services should include a primary diagnosis code that supports the emergency nature of the service. Detailed claim instructions are available on our website.

Urgent care services must be billed according to the instructions by claim submission type as provided in the following table:

Claims Submission Type	**Urgent Care Claims Instructions**
Portal	Select "Urgent" in the drop-down option of item 24c.
Electronic	Enter "Y" in 24c (SV109) and use the situational loop 2300 REF*4N*1.
Paper	Enter "U" or a "2" in Block 10d (if necessary, the "U" or "2" may be added to Block 19 instead of 10d).

Facility

Facilities should bill using a UB-04 claim form or an 837I electronic transaction. Providers must use Locator 14 on the UB-04 to indicate if the service is emergent per the prudent layperson standard, urgent, or elective. Emergency services should include a primary diagnosis code that supports the emergency nature of the service. Detailed claim instructions are available on our website.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Are urgent care services provided in an emergency department to a recipient in the PCP/HH program covered?**

   Urgent care must be referred for PCP and HH recipients. If no referral is provided, only the ER room and the physician or other licensed practitioner's screening services are covered. PCP/HH providers may grant a referral retroactively at their discretion.